



DEMYSTIFYING THE COMPLEXITIES OF ERISA CLAIMS LITIGATION

By William E. Altman and Danielle C. Lester

In 1974, Congress passed the Employee Retirement Income Security Act (ERISA). ERISA covers a voluntary “plan, fund, or program...established or maintained by an employer or by an employee organization, or by both” to provide any of the types of welfare or pension benefits described in the statute for employee participants or their beneficiaries.¹ Once employees are provided benefits through these plans, ERISA sets forth, inter alia, claims procedures, causes of action, and access to the federal courts.

Despite its specific provisions as to some aspects, ERISA does not address a number of important procedural concepts needed to enforce a claimant’s substantive rights. As a result, the federal courts have had to develop the law in these areas.² The evolution and advancement of ERISA’s civil procedure framework by the federal courts has resulted in a unique set of rules that can easily ensnare claimants and practitioners alike. Moreover, a party’s use

Fast Facts

Today, millions of people are covered under private and voluntary employee benefit plans that are governed by the Employee Retirement Income Security Act (ERISA). Once a participant or beneficiary is denied a benefit under an ERISA plan, the exercise of substantive rights of recovery hinges on a number of procedural rules. This article explains these rules and serves as a guide for successfully navigating through the complexities of ERISA claims litigation.

of these rules can substantially influence a case's outcome at both the administrative and judicial levels. Given this potential effect, this article clarifies the procedural rules governing ERISA litigation in federal courts.

Overview of ERISA Claims Litigation

A participant or beneficiary who believes he or she is entitled to a benefit under an ERISA plan must first file a claim for benefits under the plan.³ If the claim is unsuccessful, ERISA requires that the plan provide an internal review procedure in which to review claim denials.⁴ If a participant or beneficiary's claim is denied through the administrative review process, ERISA sets forth a scheme to assert substantive claims. However, before a claimant can assert a substantive claim, he or she must address and surmount a number of procedural hurdles.

Determination of ERISA's Application

The initial consideration is to determine whether ERISA governs the cause of action, and the answer first depends on whether there is a "plan" within the meaning of the statute. Generally speaking, ERISA applies to most employee welfare and pension benefit plans.⁵ However, ERISA does not apply to governmental plans; church plans; plans designed to comply with state workers' compensation laws, unemployment compensation, or disability insurance laws; plans maintained outside of the United States for nonresident aliens; and excess benefit plans (i.e., plans that provide benefits in excess of the maximum benefit contributions allowed by the Internal Revenue Code's qualification rules for highly paid individuals).⁶

Once ERISA has been determined to be applicable,⁷ the next step is to examine the plan to ascertain the administrative review process.

Exhaustion of Administrative Remedies

ERISA requires an internal claims procedure for every employee benefit plan. Section 503 of ERISA states:

In accordance with regulations of the Secretary, every employee benefit plan shall—(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.⁸

Thus, ERISA essentially provides two levels to the benefit determination: the initial determination regarding whether the claim will be paid or denied, and the second level at which a denial may be appealed internally, affording the claimant a "full and fair" review of the initial determination.

ERISA does not explicitly require exhaustion of administrative remedies. However, courts have held that "[t]he administrative scheme of ERISA requires a participant to exhaust his or her administrative remedies prior to commencing suit in federal court."⁹ The rationale behind finding an exhaustion requirement is the strong federal interest encouraging private resolution of ERISA disputes.¹⁰ Accordingly, subject to only a few narrowly construed exceptions, federal courts will not consider the merits of a claim when the claimant has failed to exhaust his or her administrative remedies under the plan.

If a claimant has exhausted his or her administrative remedies but not achieved a desirable outcome, the next step is to determine the appropriate cause(s) of action under the facts of the case.

ERISA Causes of Action

There are a variety of causes of action in connection with a benefit denial under ERISA, each with different classes of plaintiffs, defendants, and remedies. First, there is a Section 502(a)(1)(B) claim, which provides relief to a plan participant or beneficiary to recover benefits due under the plan.¹¹ The intent of this cause of action is to permit a participant or beneficiary to enforce monetary rights under the plan's terms. This specific cause of action also provides equitable relief to enforce the payments due under the plan or offer declaratory relief for the claimant's right to benefits under the plan. The defendant in this cause of action may be the plan, as it may be liable to pay benefits, or the plan administrator, if it has been granted discretionary authority to interpret plan provisions and determine eligibility for benefits.



ERISA Section	Cause of Action	Appropriate Defendant	Relief Available
502(a)(1)(B) 29 USC 1132(a)(1)(B)	Recover benefits due under the plan	Plan as it is liable to pay benefits OR Plan administrator if it has discretionary powers under the plan to interpret plan provisions and determine eligibility for benefits	Equitable relief to enforce the payment of benefits due under the plan OR Declaratory relief as to the claimant's right to benefits under the plan
502(a)(2) 29 USC 1132(a)(2)	Breach of fiduciary duty	Plan administrator on theory that either (1) plan administrator as fiduciary is required under the plan to pay benefits in accordance with the plan terms and failure to do so constitutes a breach of that fiduciary duty or (2) that systemic failure to pay benefit claims may rise to the level of a fiduciary duty breach	Limited to relief under this specific cause of action to the plan as a whole, and not individual relief
502(a)(3) 29 USC 1132(a)(3)	Enjoin activities that violate ERISA or the terms of the plan to obtain equitable relief to redress such violations; claims not covered specifically under the other subsections of ERISA Section 502 may fall under this catch-all provision	Plan fiduciary OR Non-fiduciary who allegedly violated ERISA or the terms of the plan	"Appropriate equitable relief" <i>but</i> courts are in agreement that relief under this cause of action is generally denied if the individual participant/beneficiary is seeking relief under both Sections 502(a)(1)(B) and 502(a)(3) in the same suit
510 29 USC 1140	Anti-retaliation	"Any person"	"Appropriate equitable relief" under Section 502(a)(3)

Second, there is a Section 502(a)(2) claim, which provides for a suit alleging breach of fiduciary duty.¹² These claims can arise when the plan administrator fails to pay benefits in accordance with the plan's terms or when a systemic failure to pay benefit claims rises to the level of breach of fiduciary duty. Importantly, the Supreme Court has held that, in the case of defined benefit pension plans, relief under Section 502(a)(2) is only available when an administrator's misconduct breaches fiduciary and statutory-imposed duties causing harm to a plan as a whole rather than individuals.¹³ This is due, in part, because "[m]isconduct by the administrators of a defined benefit plan will not affect an individual's entitlement to a defined benefit unless it creates or enhances the risk of default by the entire plan."¹⁴ However, the Supreme Court has also held that a participant in a defined contribution pension plan may sue a fiduciary whose alleged misconduct impaired the value of "plan assets" in the participant's individual account under Section 502(a)(2).¹⁵

Third, there is a Section 502(a)(3) claim to enjoin activities that violate ERISA or the terms of the plan to obtain other equitable relief to redress such violations.¹⁶ Courts are in agreement that a claim under Section 502(a)(3) is not appropriate if an adequate remedy is available under the other 502 sections of ERISA.¹⁷ Remedies under this cause of action entail only "appropriate equitable relief," which includes only typical remedies available in equity and not "legal remedies" like compensatory damages or monetary relief.¹⁸ The Supreme Court has held that Section 502(a)(3) authorizes lawsuits for individualized equitable relief for breach

of fiduciary obligations when the plan administrator deliberately misleads the beneficiaries of the plan.¹⁹

Finally, there is a Section 510 claim that has been referred to as ERISA's anti-retaliation provision.²⁰ ERISA Section 510 provides:

It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan... for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan.²¹

ERISA Section 510 does not contain an enforcement or remedial provision. Accordingly, courts generally look to ERISA Section 502(a)(3) to determine standing. Similar to other claims brought under Section 502(a)(3), a plaintiff may seek to prove that "but for" the employer's misconduct, he or she would have continued to enjoy participant status and, therefore, is entitled to pursue a remedy under Section 510.²² In other words, an employer cannot discharge an employee in violation of Section 510 and then argue that the former employee is no longer a participant without standing to sue under Section 510. Moreover, beneficiaries are equally entitled to pursue suit under ERISA Section 510, thus suggesting that an employment relationship is not the *sine qua non* of a Section 510 claim.²³

The chart above can be used as a quick reference guide for ERISA causes of action.

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Judicial Administration of ERISA Litigation

The ERISA civil procedure framework does not end with the determination of the appropriate cause(s) of action because there are a number of other considerations pertinent to the judicial administration of ERISA litigation, such as:

- The appropriate statute of limitations for the cause of action
- The judicial standard of review applicable to the fiduciary's decision to deny the claim
- Whether the courts are limited by the administrative record of the plan's fiduciary or whether new evidence may be submitted by the plaintiff

Statute of Limitations

ERISA does not contain any provisions regarding statute of limitations for benefit claims. However, most courts have held that the forum state's most analogous statute of limitations—generally for breaches of contract—governs a benefits claim.²⁴ Some courts have, however, recognized that the plan may impose a shorter statute of limitations, if reasonable.²⁵

Judicial Standard of Review

The statutory language of ERISA is silent regarding the applicable standard of review of causes of action, including the denial of benefits. Although ERISA itself is silent on the standard for denials of benefits, the United States Supreme Court has established that a *de novo* standard applies “unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.”²⁶ If a plan grants the fiduciary discretionary authority, a court will give

that decision great deference and only review the matter to determine if the actions by the fiduciary were arbitrary and capricious.²⁷ A determination by plan trustees will not be found to be arbitrary and capricious if it is “rational in light of the plan's provisions.”²⁸ In other words, “when it is possible to offer a reasoned explanation, based on the evidence, for a particular outcome, that outcome is not arbitrary or capricious.”²⁹

In litigating an ERISA benefit denial case, it is critical whether the court applies a *de novo* standard or an arbitrary and capricious standard in reviewing the plan administrator's decision. The claimant obviously prefers the *de novo* standard, as it affords an independent review of the decision by the courts, whereas the defendant prefers the highly deferential arbitrary and capricious standard, affirming the plan administrator's decision unless it was “arbitrary and capricious.” Oftentimes, the determination of which standard applies will substantially impact the outcome of the case.



Evidentiary Issues at the Time of Adjudication

An issue that arises in benefit denial cases is whether the court is limited to evidence presented before the plan administrator during the review process. The courts have determined that the resolution of this issue depends on the applicable standard of review to be applied in the given cases. In cases where the arbitrary and capricious standard is applicable, courts limit the evidence presented at court to that contained in the administrative record.³⁰ The court may consider evidentiary materials outside of the administrative record only if there is some kind of procedural challenge against the plan administrator, such as an alleged lack of due process afforded by the administrator or alleged bias on the administrator's part.³¹ In cases where the court finds that the plan administrator improperly declined to review information that should have been part of the administrative record, the proper recourse is to remand the issue to the plan administrator for redetermination.³²

Conclusion

Since ERISA's enactment in 1974, the federal courts have developed a federal common law on procedural and substantive rules where ERISA is silent. The evolution of these rules through the years has resulted in a unique framework that plays out at both the administrative and judicial levels. This article has presented some of the pertinent topics associated with ERISA claims litigation in an attempt to highlight the important rules applicable to adjudication of benefit claims under ERISA plans. However, ERISA is a highly complex statute, so general practitioners should consult a specialist if they become involved in any ERISA claims litigation. ■



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FOOTNOTES

- 29 USC 1002(1) and (2)(A).
- See *Pilot Life Ins Co v Dedeaux*, 481 US 41, 56; 107 S Ct 1549; 95 L Ed 2d 39 (1987) (directing the lower federal courts to develop a "federal common law of rights and obligations under ERISA-regulated plans").
- See 29 USC 1133.
- 29 USC 1133(2).
- See generally 29 USC 1002(1) and (2) (defining an employee welfare benefit plan and an employee pension benefit plan).
- 29 USC 1003(b).
- Assuming, *arguendo*, that ERISA governs the particular plan, then ERISA preempts all state law causes of action that duplicate, supplement, or supplant the civil enforcement remedy provided in the statute. *Aetna Health, Inc v Davila*, 542 US 200, 209; 124 S Ct 2488; 159 L Ed 2d 312 (2004). A discussion on ERISA preemption exceeds the scope of this article.
- 29 USC 1133.
- Constantino v TRW Inc*, 13 F3d 969, 974 (CA 6, 1994); *Miller v Metropolitan Life Ins Co*, 925 F2d 979, 986 (CA 6, 1991).
- See *Borman v Great Atl & Pac Tea Co, Inc*, 64 Fed Appx, 524, 529 (CA 6, 2003).
- 29 USC 1132(a)(1)(B).
- 29 USC 1132(a)(2) (providing a cause of action for violations for breaches of fiduciary duties, with the requisite relief provided under 29 USC 1109).
- Massachusetts Mut Life Ins Co v Russell*, 473 US 134, 140; 105 S Ct 3085; 87 L Ed 2d 96 (1985).
- LaRue v DeWolff, Boberg & Associates, Inc*, 552 US 248, 255; 128 S Ct 1020; 169 L Ed 2d 847 (2008).
- Id.* at 256.
- 29 USC 1132(a)(3).
- See *Varity Corp v Howe*, 516 US 489, 512-515; 116 S Ct 1065; 134 L Ed 2d 130 (1996); *Marks v Newcourt Credit Group, Inc*, 342 F3d 444, 454 (CA 6, 2003).
- Mertens v Hewitt Assocs*, 508 US 248, 260; 113 S Ct 2063; 124 L Ed 2d 161 (1993).
- Varity Corp*, 516 US at 506.
- Mattei v Mattei*, 126 F3d 794, 797 n 4 (CA 6, 1997).
- 29 USC 1140.
- Shahid v Ford Motor Co*, 76 F3d 1404, 1410 (CA 6, 1996).
- Mattei*, 126 F3d at 801.
- See, e.g., *Santino v Provident Life & Acc Ins Co*, 276 F3d 772, 776 (CA 6, 2001).
- See, e.g., *Morrison v Marsh & McLennan Cos, Inc*, 439 F3d 295, 302 (CA 6, 2006); *Northlake Reg'l Med Ctr v Waffle House Sys Emp Benefit Plan*, 160 F3d 1301, 1303 (CA 11, 1998); *Doe v Blue Cross & Blue Shield*, 112 F3d 869, 875 (CA 7, 1997).
- Firestone Tire & Rubber Co v Bruch*, 489 US 101, 115; 109 S Ct 948; 103 L Ed 2d 80 (1989).
- Marks*, 342 F3d at 456.
- Spangler v Lockheed Martin Energy Systems, Inc*, 313 F3d 356, 361 (CA 6, 2002).
- Id.*
- Rochow v Life Ins Co of North America*, 482 F3d 860, 865 (CA 6, 2007).
- Moore v Lafayette Life Ins Co*, 458 F3d 416, 430 (CA 6, 2006).
- See *Killian v Healthsource Provident Administrators, Inc*, 152 F3d 514, 522 (CA 6, 1998) (remanding to consider the additional evidence as the administrative record was inadequate).